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Issue Date: 05 September 2007

CASE NO.: 2004-BLA-5236

E.G., Widow of
I.G., Claimant,

v.

U.S. STEEL CORPORATION,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR
Party-in-Interest.

Appearances:

Sandra M. Fogal, Esquire
For Claimant

Howard Salisbury, Esquire
For Employer

Before: STEPHEN L. PURCELL
Associate Chief Judge

DECISION AND ORDER AWARDING BENEFITS

This case arises from a claim for benefits under the "Black Lung Benefits Act," Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. §901 et seq. (hereinafter referred to as "the Act"), and applicable federal regulations, mainly 20 C.F.R. Parts 410, 718 and 727 ("Regulations").

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to the survivors of persons whose deaths were

caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as black lung.[1]

A formal hearing was held on December 2, 2005 in Charleston, West Virginia. At that time all parties were afforded a full opportunity to present evidence and argument, as provided in the Act and Regulations issued thereunder, found in Title 20, Code of Federal Regulations.[2]

ISSUES

The contested issues are:

1. Whether the miner suffered from pneumoconiosis;
2. Whether the miner's pneumoconiosis arose out of his coal mine employment; and
3. Whether the miner's death was due to pneumoconiosis. TR 8; DX 26.

Although issues 1 and 2 were contested at the hearing, Employer, in its closing brief, appears to be conceding these issues. Employer's brief pages 2-8. After a review of the evidence, I find that the autopsy report supports a diagnosis of pneumoconiosis pursuant to §718.202 and that the reviewing pathologists agreed on this issue. As there is no contrary evidence in the record, I find that Claimant has established the presence of pneumoconiosis. Since the miner had greater than ten years of coal mine employment, he is entitled to the presumption that his pneumoconiosis arose out of his coal mine employment. Employer has not provided any credible evidence to rebut said presumption. Therefore I find Claimant has established that the miner's pneumoconiosis arose out of his coal mine employment pursuant to §718.203. The sole issue is thus whether the miner's death was due to pneumoconiosis.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History and Factual Background[3]

The miner filed his first claim for benefits on April 9, 1973. DX 1. On July 19, 1979, the claims examiner found that the miner met the disability standards but that since the miner was still working, benefits may not be granted. DX 1. After additional evidence was developed, the deputy commissioner issued a finding on May 26, 1981 that the miner was not entitled to

[1] The following abbreviations have been used in this opinion: DX = Director's exhibit, EX = Employer/Carrier's exhibit, CX = Claimant's exhibit, TR = Transcript of the hearing, BCR = Board-certified radiologist, BCI = Board-certified internist, and B = B reader.

[2] At the hearing, Director's exhibits 1 through 28 were admitted into evidence without objection. TR 6. Claimant's exhibit 1 and Employer's exhibits 1 and 2 were admitted into evidence. TR 10, 13. In compliance with the Court's orders, post-hearing, Claimant submitted a letter designating additional evidence from the deceased miner's claims. This letter, dated December 9, 2005, is marked ALJ 1 and is hereby admitted into evidence. Employer did not submit any rebuttal evidence. On April 27, 2006, I issued an Order Closing the Record and Setting Briefing Schedule. Employer filed its closing brief on May 31, 2006 and Claimant filed her brief on May 31, 2006.

[3] Given the filing date of this claim, subsequent to the effective date of the permanent criteria of Part 718, (i.e. March 31, 1980), the regulations set forth at 20 C.F.R. Part 718 will govern its adjudication. Because the miner's last exposure to coal mine dust occurred in West Virginia this claim arises within the territorial jurisdiction of the United States Court of Appeals for the Fourth Circuit. *See Broyles v. Director, OWCP*, 143 F.3d 1348, 21 BLR 2-369 (10th Cir. 1998).

benefits. DX 1. The miner did not respond to the finding and on August 12, 1981, the claim was closed.

The miner filed his second claim for benefits on July 13, 1992. DX 2. On January 4, 1993, the claims examiner issued a denial of benefits. Thereafter the claim was apparently closed. DX 2.

On October 10, 2002, Claimant filed her application for survivor's benefits. DX 3. On July 31, 2003, the district director issued a Proposed Decision and Order – Awarding Benefits. DX 21. Employer disagreed and requested a formal hearing. DX 22.

At the hearing, Claimant testified that she was married to the miner in 1954. She has not remarried. TR 24. She stated that from 1967 to 1978 they lived very close to the mine where the miner worked. TR 24. She was able to see him working from the house. TR 24. She could see that it was dusty and dirty. TR 25. She noticed that the miner had trouble breathing beginning in 1978. TR 25. The miner was very short of breath by October of 1983 when he finally left the mines. TR 25. They built a ramp onto their house in 1992 to help him get in and out of the house. TR 26. He could no longer help around the house, and he could not work on their cars. TR 27. By 1999, the miner could not do much of anything due to his breathing. TR 27. Drs. Milner and Lee were the miner's treating physicians. TR 28-29. Dr. Lee treated the miner up until about one year before his death (April 2002). TR 29. He prescribed antibiotics, cough syrups, and pain medication for the miner. TR 29. The miner then started seeing Dr. Lee's daughter, Dr. Wirtz. TR 31. He saw Dr. Wirtz on two occasions for congestion problems. TR 32. Claimant believed her husband had a stroke in 1998. TR 33. The miner started receiving hospice care in September of 2002 and died on October 1, 2002. TR 34. Claimant stated that the miner started smoking cigars in 1983. TR 35. He would light a cigar 10-15 times per day but would only take a puff then would put it down for a few hours. TR 35. He smoked up until two years before his death (2000). TR 35. The miner had high blood pressure and had borderline diabetes. TR 36. Claimant stated that the miner started using a wheelchair in 2000. TR 38.

Medical Evidence

Chest X-rays[4]

Exhibit Number	Date of X-ray	Physician/Qualifications	Diagnosis
DX 2	11-13-92	Francke/ BCR, B	Negative
DX 2	11-13-92	Kugel/ BCR	Negative

[4] Counsel for Claimant, by letter of 12-9-05, designated the 11-13-92 chest x-ray interpretation by Dr. Francke and the *11-19-92* chest x-ray interpretation by Dr. Kugel from Director's exhibit 2. However, there is no 11-19-92 chest x-ray in the record. Counsel noted in her closing brief that there were two negative chest x-ray interpretations in the record from 11-13-92. *Claimant's closing brief, page 6.* Based on the foregoing I can reasonably conclude that it was Claimant's intention to designate as evidence the *11-13-92 interpretation by Dr. Kugel* as evidence in this case.

Arterial Blood Gas Studies

Exhibit	Date	PO2	PCO2	Qualify
DX 1	4-4-79	53 *65	21 *20	Yes Yes

Medical Reports

Dr. James Walker

The medical report of Dr. Walker is dated September 11, 1992 and appears at DX 2.[5] This report was designated by Claimant as evidence in this matter. Dr. Walker reviewed the occupational history of the miner and noted a family history of high blood pressure and heart disease. He noted an individual medical history positive for frequent colds, attacks of wheezing, arthritis, allergies, and high blood pressure. He noted a smoking history of two cigars per day for many years and stopping in 1980. The miner's chief complaints were cough with sputum, wheezing, and dyspnea. Physical examination of the chest was unremarkable. A chest x-ray was read as negative for CWP, a vent study was normal, and resting arterial blood gases were normal. Dr. Walker concluded there was no evidence of pneumoconiosis. He opined that the miner did not have any pulmonary impairment that would prevent him from performing his last coal mine employment.

Miscellaneous Medical Records

Charleston Area Medical Center

The discharge summary from July 14, 1992 was designated as evidence by Claimant in this matter. DX 2. It was noted that the miner was admitted on July 7, 1992 for arthroplasty for degenerative arthritis of the hip. Final diagnosis was listed as degenerative arthritis of the hip, hypertension, hypokalemia, mild iron deficiency anemia, and pulmonary fibrosis due to coal worker's pneumoconiosis.

Death Certificate

The death certificate is dated October 7, 2002 and appears at DX 11. The miner's date of death was October 1, 2002. The death certificate was certified by Dr. A. Wirtz. The immediate cause of death was listed as cerebrovascular accident.

[5] In the same letter, counsel for Claimant also designated the medical report of Dr. Walker dated *September 11, 1972* in Director's exhibit 2. However, the only medical report from Dr. Walker in DX 2 is dated September 11, 1992. Counsel for Claimant references the examination by Dr. Walker in her closing brief noting that he examined the miner in 1992. *See Claimant's closing brief, page 7.* Based on the foregoing, I can reasonably conclude Claimant meant to designate as evidence the *September 11, 1992 report of Dr. Walker found at DX 2*.

Autopsy

An autopsy limited to the chest was performed on October 2, 2002 by Dr. Richard Fulks. DX 12. His final diagnoses were extensive, acute bilateral pneumonia, cardiovascular disease, macular lesions of simple coal worker's pneumoconiosis, and lymphadenopathy. In the Final Summary/Comments section, Dr. Fulks stated that the miner was 72 years old at the time of death. He noted that the miner had extensive acute pneumonia, the coronary arteries showed atherosclerosis with up to 70% narrowing of the lumen, and there was evidence of pneumoconiosis. Macular lesions measuring up to 7 mm were present bilaterally. He noted that these macules were not grossly palpable and did not contain appreciable amounts of birefringent collagen. He described a micronodular lesion in the central right upper lobe and a subpleural fibrotic nodule in the left lower lobe. Multiple nodules were noted in the lymph nodes. He opined that based on the examination of the chest, the immediate cause of death was acute pneumonia. Progressive massive fibrosis was not found and there was no evidence of neoplasia.

In a letter to Claimant dated February 10, 2003, Dr. Fulks stated that the autopsy showed pneumoconiosis in the form of macular lesions with a single micronodular lesion in the right upper lobe. DX 13. He opined that the immediate cause of death was acute pneumonia and the anterior apex of the left ventricle had an organizing acute myocardial infarct. He recommended that Claimant send questions to the miner's treating physician.

Post-Mortem Reports

Dr. Amy Wirts

On February 12, 2003, Dr. Wirts completed a questionnaire regarding the miner's death. DX 14. She stated that the miner had an occupational lung disease caused by coal mine employment based on the autopsy report. She noted that the miner's respiratory condition was substantially aggravated by coal mine dust exposure. She noted that the miner was a non-smoker when asked if there was some other factor, in addition to coal mine dust, that could have caused lung disease. Dr. Wirts opined that pneumoconiosis was a substantial contributing factor in causing the miner's death. She concluded that the miner's immediate cause of death was acute pneumonia substantially aggravated by pneumoconiosis. She stated that she treated the miner from December of 2001 to October of 2002.

The deposition of Dr. Wirts was taken on June 24, 2003 and appears at EX 2. This deposition was noticed by Employer. Counsel for Claimant did not appear at the deposition. Dr. Wirts is Board-Certified in Internal Medicine. She has been practicing medicine for three years. She stated that she first saw the miner on October 30, 2001 when she took over the medical practice of her father, Dr. Lee. The miner had arthritis of multiple joints and was bedfast when she first saw him. She noted that he had high blood pressure, diabetes, and vascular dementia (memory impairment). She saw the miner every three months and last saw him on July 31, 2002. She never treated the miner for breathing problems. Dr. Wirts had one chest x-ray in her file from January of 2002. It not address whether the miner had pneumoconiosis. She was the miner's physician at the time of death and she signed the death certificate. She listed a CVA

(stroke) as the cause of death. Dr. Wirts was told by Claimant that the miner had been bedfast since July. From this conversation Dr. Wirts believed that the miner had suffered a stroke. She did not review the autopsy report before completing the death certificate. She agreed that since the autopsy was limited to the chest a cause of death may not be able to be determined. In reference to the questionnaire, Dr. Wirts stated that she based her diagnosis of pneumoconiosis on the autopsy report. She concluded that the pneumonia was substantially aggravated by coal mine dust exposure based on the autopsy findings. She knew from Claimant that the miner was a coal miner and that he was a non-smoker. According to her records, the miner had not smoked since 1994, before then she did not have any knowledge. She stated that due to the limited scope of the autopsy she was not certain of the cause of death. She agreed that the opinions listed on the questionnaire were solely based on the autopsy report. Dr. Wirts noted that the miner could have been developing symptoms of pneumonia in July of 2002 and may have not suffered a stroke as she initially thought.

Dr. Stephen Bush

The medical report of Dr. Bush is dated August 11, 2003 and appears at EX 1. Dr. Bush is Board-Certified in Anatomic and Clinical Pathology. EX 1. He reviewed the histologic slides from the autopsy plus reviewed and summarized the death certificate, the autopsy report, a letter from Dr. Fulks, and the deposition transcript of Dr. Wirts. He noted that there were coal dust macules and micronodules measuring up to 0.5cm in every histologic slide. He stated that the lesions consisted of a relatively small amount of coal dust pigment in macrophages and free in the tissue with a moderate number of birefringent particles of silica and silicates, associated with fibrous reaction, forming stellate lesions surrounded by a small amount of focal dust emphysema. He opined that the lesions were more numerous in the upper lobes and affected about 5% of the lung substance. Dr. Bush added that the most prominent finding in the lungs was acute bronchopneumonia. He found a mild degree of change consistent with chronic bronchitis. Examination of the heart tissue indicated a myocardial infarct several weeks or months before death. Dr. Bush concluded that based on the histologic findings, the miner died because of extensive acute bronchopneumonia in the setting of a patient with debilitating arthritis who was bedfast and therefore susceptible to developing pneumonia.

Dr. Bush opined that due to the limited amount of CWP (less than 5% of lung tissue affected) this disease would not have contributed in any way to the death of the miner. The extent of pneumoconiosis would not have caused any respiratory symptoms and would not have hastened the death of the miner. Dr. Bush disagreed with the cause of death in the death certificate noting he found no evidence of a CVA. He stated that the absence of radiological evidence of lung disease, the absence of respiratory complaints to Dr. Wirts during the last years of life, the absence of a significant extent of pneumoconiosis on gross and microscopic examination at autopsy provide convincing evidence that CWP did not cause, contribute to, hasten, or in any way produce a complication which contributed to the death of the miner. He disagreed with the opinion of Dr. Wirts that the immediate cause of death was acute pneumonia substantially aggravated by pneumoconiosis.

Dr. Francis Green

The medical report of Dr. Green is dated October 20, 2005 and appears at CX 1. Dr. Green is Board-Certified in Anatomic Pathology. Dr. Green reviewed medical evidence including the autopsy slides, the autopsy report, a letter from Dr. Fulks, the death certificate, the deposition of Dr. Wirts, chest x-rays, pulmonary function studies, arterial blood gases, the miner's work history, and the medical report of Dr. Bush. Microscopic examination of the lung tissue revealed pneumoconiosis characterized by macules and micronodules with small lesions. Despite their small size, Dr. Green noted that "their profusion is severe." The lungs also showed evidence of pulmonary edema and chronic bronchitis. Smoker's macrophages were not seen. Emphysema of the centriacinar type was noted along with focal emphysema. He diagnosed the miner as having severe simple CWP, marked perivascular dust deposition with fibrosis, pulmonary vascular changes consistent with cor pulmonale, focal/centriacinar emphysema, chronic bronchitis, pulmonary edema, and widespread bronchopneumonia. He noted that the autopsy showed a severe bronchopneumonia, pneumoconiosis, and a healing myocardial infarction or thrombosis of a coronary artery. Dr. Green opined that death appeared to be cardio-pulmonary in nature involving both a compromised cardiovascular system and a compromised respiratory system. He opined that death resulted from a combination of respiratory and cardiac causes.

Dr. Green diagnosed the miner as having cor pulmonale. He noted that the right ventricle measurement was twice the normal size. In addition, the lungs showed vascular changes associated with pneumoconiosis which was in turn associated with pulmonary hypertension. He stated that cor pulmonale results from lung disease, and opined that the miner's cor pulmonale was caused by his pneumoconiosis.

Dr. Green noted that all of the pathologists diagnosed the presence of pneumoconiosis and cardiovascular disease including atherosclerosis of the coronary arteries and a resolving myocardial infarction as well as the presence of extensive acute bronchopneumonia. He added that Dr. Fulks did not provide an overall severity rating for the pneumoconiosis but described pneumoconiotic lesions in virtually every slide. Dr. Green noted that Dr. Bush, in contrast, opined the pneumoconiosis comprised only 5% of the total lung substance, and that it was his view that the pneumoconiosis was of mild severity. He further noted, however, that all of the pathologists agreed there were silicotic nodules in the miner's lungs and that all of the lesions contained large quantities of silica and silicates by polarizing microscopy.

With regard to the severity of the disease, Dr. Green explained that one reason why the chest x-rays were negative was that the majority of macules and micronodules were less than 3 mm and thus were below the resolving power of the chest x-ray. He noted that numerous studies have shown that x-rays were relatively insensitive to the macular and micronodular forms of pneumoconiosis. Dr. Green stated that although the lesions of pneumoconiosis were small they were very widespread and in many instances involved the centers of all acini in the tissue sections. Moreover there was extensive involvement of the blood vessels by the pneumoconiosis with marked deposition of dust within and around the vessels and narrowing of their walls, which changes were associated with cor pulmonale. He noted the miner demonstrated both right ventricular hypertrophy (2x normal thickness) and right ventricular dilation, which was the

pathologic hallmark of right ventricular failure as well as changes in the blood vessels associated with pulmonary hypertension. Dr. Green opined that the miner suffered from moderate/severe to severe pneumoconiosis (based on the number of acinar units involved) and that this was associated with pulmonary hypertension and cor pumonale.

Dr. Green noted there was also evidence of focal emphysema and chronic bronchitis. He explained that focal emphysema could be caused by coal mine dust as well as chronic bronchitis. He further noted that the miner smoked two cigars per day ending in 1980 and that it was highly unlikely that this cigar smoking was a major factor contributing to the emphysema and bronchitis. It was his opinion that these conditions were secondary to the 35 years of exposure to coal mine dust.

Dr. Green opined that the events leading to death appeared to be respiratory in nature and there was evidence of terminal bronchopneumonia. He concluded that the pneumoconiosis was severe enough to have contributed to the respiratory failure and also put a strain on the right heart causing cor pulmonale. It was his opinion that the pneumoconiosis was a significant contributing factor in the miner's death. He added some components of coal dust have been known to suppress the innate defense mechanisms against infection. Thus the presence of silicosis in the miner's lungs would have exacerbated and accelerated the bronchopneumonia that was the terminal event. Dr. Green concluded that the pneumoconiosis contributed to death and hastened death in three ways: (1) directly on pulmonary function, (2) through its effects on the heart (cor pulmonale), and (3) by its promotion of pulmonary infection (bronchopneumonia).

Conclusions of Law

Length of Coal Mine Employment

I find that the miner was a coal miner within the meaning of the Act for 32 years. TR 6.

Date of Filing

I find that Claimant filed her claim for benefits under the Act on October 10, 2002. DX 3.

Responsible Operator

I find that U.S. Steel Corporation is the properly designated responsible operator and will provide payment of any benefits awarded to Claimant. DX 26; TR 5.

Dependents

I find that Claimant is an eligible survivor of the miner. DX 26; TR 24. Claimant did not claim to have any other dependents for purposes of augmentation of benefits under the Act. DX 3; TR 6.

Entitlement to Benefits

Standard of Review

The administrative law judge need not accept the opinion of any particular medical witness or expert, but must weigh all the evidence and draw his/her own conclusions and inferences. *Lafferty v. Cannelton Industries, Inc.*, 12 B.L.R. 1-190 (1989); *Stark v. Director, OWCP*, 9 B.L.R. 1-36 (1986). The adjudicator's function is to resolve the conflicts in the medical evidence; those findings will not be disturbed on appeal if supported by substantial evidence. *Lafferty, supra; Short v. Westmoreland Coal Co.*, 10 B.L.R. 1-127 (1987); *Piccin v. Director, OWCP*, 6 B.L.R. 1-616 (1983).

In considering the medical evidence of record, an administrative law judge must not selectively analyze the evidence. See *Wright v. Director, OWCP*, 7 B.L.R. 1-475 (1984); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Crider v. Dean Jones Coal Co.*, 6 BLR 1-606 (1983); see also *Stevenson v. Windsor Power House Coal Co.*, 6 B.L.R. 1-1315 (1984). The weight of the evidence, and determinations concerning credibility of medical experts and witnesses, however, is for the administrative law judge. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986); *Brown v. Director, OWCP*, 7 B.L.R. 1-730 (1985); see also *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Henning v. Peabody Coal Co.*, 7 B.L.R. 1-753 (1985).

As the trier-of-fact, the administrative law judge has broad discretion to assess the evidence of record and determine whether a party has met its burden of proof. *Kuchwara v Director, OWCP*, 7 BLR 1-167 (1984). In considering the evidence on any particular issue, the administrative law judge must be cognizant of which party bears the burden of proof. Claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. See *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Entitlement: In General

To establish entitlement to survivor's benefits, claimant must establish that the miner had pneumoconiosis, that the miner's pneumoconiosis arose out of coal mine employment, and that the miner's death was due to pneumoconiosis. 20 C.F.R. §§718.3, 718.202, 718.203, 718.205(a); *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Haduck v. Director, OWCP*, 14 B.L.R. 1-29 (1990); *Neeley v. Director, OWCP*, 11 B.L.R. 1-85 (1988); *Boyd v. Director, OWCP*, 11 B.L.R. 1-39 (1988). For survivor's claims filed on or after January 1, 1982, the miner's death will be considered due to pneumoconiosis if pneumoconiosis was the cause of the miner's death, was a substantially contributing cause or factor leading to the miner's death, death was caused by complications of pneumoconiosis, or the presumption, relating to complicated pneumoconiosis, set forth at Section 718.304 is applicable. 20 C.F.R. §718.205(c)(1)-(3). Pneumoconiosis is a substantially contributing cause of death if it hastened the miner's death. 20 C.F.R. §718.205(c)(5); *Shuff v. Cedar Coal Co.*, 967 F.2d 977, 16 B.L.R. 2-90 (4th Cir. 1992), *cert. denied*, 506 U.S. 1050 (1993).

Death Due to Pneumoconiosis

The sole issue in this case is whether the miner's death was due to pneumoconiosis.

Subsection 718.205(c) applies to survivor's claims filed on or after January 1, 1982 and provides that death will be due to pneumoconiosis if any of the following criteria are met:

(1) competent medical evidence established that the miner's death was due to pneumoconiosis; or
(2) pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis; or
(3) the presumption of §718.304 [complicated pneumoconiosis] is applicable.

Pursuant to §718.205(c)(5), pneumoconiosis is a substantially contributing case of a miner's death if it hastens the miner's death.

There is no evidence that pneumoconiosis was the direct cause of the miner's death. Therefore, Claimant has not proven death due to pneumoconiosis pursuant to §718.205(c)(1). There is also no credible evidence the miner suffered from complicated pneumoconiosis. Therefore, Claimant has not established death due to pneumoconiosis pursuant to §718.205(c)(3).

There are four opinions in the record relevant to this issue. Dr. Fulks, the autopsy prosector, diagnosed the presence of pneumoconiosis but opined that the apparent cause of death was acute pneumonia. Dr. Amy Wirts opined that the miner's pneumoconiosis was a substantial contributing factor to the miner's death. Dr. Bush opined the pneumoconiosis was too minimal to have contributed to the miner's death. Dr. Green opined that the pneumoconiosis was severe enough to have contributed to the miner's respiratory failure, that the pneumoconiosis put a strain on the right heart causing cor pulmonale, and that pneumoconiosis was a significant contributing factor in the miner's death.

I accord less weight to the opinion of Dr. Fulks. In his supplemental letter, in response to an apparent inquiry by Claimant, Dr. Fulks noted the presence of pneumoconiosis and opined that the immediate cause of death was acute pneumonia. He recommended to Claimant that any further questions be sent to the miner's treating physician. Based on this response, I find that Dr. Fulks was not comfortable making an assessment regarding the relationship between the pneumoconiosis found at autopsy and the miner's death. Because he did not discuss the impact of the miner's pneumoconiosis on the miner's respiratory system and ultimate demise from acute pneumonia, I accord his opinion less weight.

With respect to the opinion of Dr. Wirts, I note that the adjudication officer must give consideration to the relationship between the miner and any treating physician whose report is admitted into evidence. Factors to consider include the nature of the relationship, duration of the relationship, frequency of treatment, and extent of treatment. §718.104(d). In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling

weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole. §718.104(d)(5). Claimant testified that Dr. Wirts treated the miner on several occasions prior to his death.

The record contains the medical report and deposition testimony of Dr. Wirts. In her medical report she stated that she treated the miner from December of 2001 to October of 2002. DX 14. At her deposition she testified that she first saw the miner on October 30, 2001 and that she saw him every three months ending on July 31, 2002. EX 2. Claimant testified at the hearing that the miner saw Dr. Wirts on only two occasions. TR 32. There is no medical evidence in the record, such as the office notes of Dr. Wirts, to document any of these claims. I find that based on the foregoing, Dr. Wirts treated the miner 2-3 times from the end of 2001 through July of 2002. Claimant testified at the hearing that Dr. Wirts treated the miner for congestion. TR 32. However, Dr. Wirts testified that she never treated the miner for breathing problems. EX 2. There is no evidence that Dr. Wirts had any greater understanding of the miner's respiratory condition than any of the other medical consultants in this case. Based on the foregoing, I find that there is insufficient evidence in the record to justify according greater weight to the opinion of Dr. Wirts based on her relationship with the miner.

Moreover, assuming arguendo that her opinion is entitled to greater weight under the "treating physician" rule, I find that the opinion of Dr. Wirts is not well-reasoned and is not well-documented for several reasons. First, she based her opinion that pneumoconiosis was a substantial contributing factor in the miner's death solely on the autopsy report, and gave no other explanation which might support her conclusion. Second, she admitted at her deposition that, after reviewing the limited autopsy, she was not certain of the cause of death. Clearly, if she is unable to identify a cause of death then she cannot, with any degree of medical certainty, conclude that pneumoconiosis was a substantial contributing cause of death. Third, according to her records and her deposition testimony, Dr. Wirts believed that the miner was a non-smoker. This belief, however, is contrary to the evidence of record[6] and tends to further undermine the weight of her opinion. Fourth, Dr. Wirts signed the miner's death certificate and listed the immediate cause of death as a stroke (CVA). DX 11. At her deposition, however, Dr. Wirts testified that she based her conclusion regarding the cause of death on a phone call from Claimant in September of 2002 during which she was informed that the miner could no longer get out of bed. As noted above, after reviewing the autopsy report Dr. Wirts was no longer certain the miner had suffered a stroke as she had previously thought. Based on the foregoing, it is clear that Dr. Wirts was not uniquely familiar with the miner's condition at the time of death, that she based her opinion solely on the autopsy report, and that she provided no rationale for her conclusion regarding the cause of the miner's death. I simply do not find her opinion credible.

[6] Claimant testified at the hearing that the miner started smoking cigars in 1983 and smoked until 2000. TR 35. However, Dr. Walker noted, in his medical report from 1992, that the miner smoked two cigars a day for many years ending in 1980. DX 2. Claimant testified that she married the miner in 1954. TR 24. I find that the history contained within Dr. Walker's report is likely inaccurate since Claimant, the miner's wife, would have been acquainted with the miner's smoking history than Dr. Walker. Based on Claimant's credible testimony, it appears that the miner had a history of smoking cigars for at least 17 years ending in 2000.

Likewise, I accord less weight to the negative opinion of Dr. Bush than the contrary positive opinion of Dr. Green. After noting the presence of coal worker macules and micronodules measuring up to 0.5 cm in *every* histologic slide, Dr. Bush opined that the pneumoconiosis affected only 5% of the miner's lung substance and would have resulted in no respiratory impairment. He further opined that the limited amount of CWP present would not have contributed to the miner's death due to extensive acute bronchopneumonia. Conversely, Dr. Green examined the autopsy slides and concluded the miner had severe simple CWP, marked perivascular dust deposition with fibrosis, pulmonary vascular changes consistent with cor pulmonale, focal/centriacinar emphysema, chronic bronchitis, pulmonary edema, and widespread bronchopneumonia.

Dr. Bush relied on the negative chest x-rays in support of his opinion. However, Dr. Green persuasively explained that one reason why the chest x-rays were negative was that the majority of macules and micronodules were less than 3 mm and thus were below the resolving power of the chest x-ray. He added that although the lesions were small, they were very widespread and in many instances involved the centers of all acini in the tissue sections. Dr. Bush did not describe the miner's cardiovascular changes whereas Dr. Green convincingly explained the pathologic basis for his diagnosis of cor pulmonale.[7]

Moreover, Dr. Bush relied in part on the miner's lack of respiratory complaints to Dr. Wirts to support his opinion. However, there is evidence in the record from Dr. Walker (the 1992 report at DX 2) and Claimant (TR 25, 27) that the miner had respiratory symptoms as far back as 1978. Furthermore, Dr. Bush provides no explanation for his calculation that the lesions compromised only 5% of the lung substance, whereas Dr. Green noted that the sections of lung obtained during the autopsy, which were "exceedingly well sampled," revealed lesions of pneumoconiosis which, although small, were "severe [in their profusion]" and "occup[ied] all of the centriacinar respiratory units" in a majority of the sections. Based on the foregoing, I accord the opinion of Dr. Bush less weight.

I accord great weight to the highly qualified opinion of Dr. Green. His opinion is well-reasoned and well-documented on this issue. He opined that the events leading to death appeared to be respiratory in nature and that there was evidence of terminal bronchopneumonia. In fact all of the pathologists (Drs. Green, Bush, and Fulks) agreed that bronchopneumonia was the cause of death in this case. As discussed above, Dr. Green presented a persuasive case that the miner suffered from widespread pneumoconiosis (as opposed to Dr. Bush's assessment of 5% of lung substance) that he classified as severe and that the miner suffered from cor pulmonale. After a thorough and detailed analysis of the miner's medical condition, Dr. Green ultimately concluded that pneumoconiosis was a significant contributing factor to the miner's death noting it would have exacerbated and accelerated the bronchopneumonia which was the terminal event. He also pointed to a study that linked some components of coal dust to the suppression of innate defense mechanisms against infection. Based on all of the foregoing, Dr.

[7] Dr. Green was apparently given an incorrect smoking history of two cigars per day ending in 1980. I therefore find that his opinion regarding the etiology of the miner's focal emphysema may not be entirely reliable. Nonetheless, I find that this error does not affect the overall credibility of Dr. Green or his ultimate conclusion that the miner's pneumoconiosis was severe enough to have contributed to the respiratory failure and put a strain on the right heart causing cor pulmonale.

Green concluded that the pneumoconiosis contributed to and hastened death in three ways: (1) directly on pulmonary function, (2) through its effects on the heart (cor pulmonale), and (3) by its promotion of pulmonary infection (bronchopneumonia). I find the foregoing credible and convincing.

Conversely, because I find that the extent of the pneumoconiosis was more severe than that diagnosed by Dr. Bush, I find that the basis for Dr. Bush's opinion (i.e. that the pneumoconiosis was too mild to contribute to death) is not credible.

Based on the foregoing, I find that Claimant has established by a preponderance of the evidence that the miner's death was due to pneumoconiosis pursuant to Section 718.205(c).

Conclusion

Because Claimant has established all elements of entitlement, I must conclude that she is entitled to benefits under the Act.

Date of Entitlement to Benefits

Since the miner died on October 1, 2002, Claimant is entitled to receive benefits, as his surviving spouse, commencing as of October 1, 2002. See 20 C.F.R. §725.212 and §725.213(a).

Attorney's Fees

No award of attorney's fees for services to the Claimant is made herein since no application has been received. Thirty days are hereby allowed to Claimant's counsel for the submission of such application. Her attention is directed to 20 C.F.R. §§725.365 and 725.366 of the regulations. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. Parties have ten days following receipt of such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

IT IS HEREBY ORDERED that the claim of E.G., as surviving spouse of I.G., for black lung benefits under the Act is GRANTED, and that U.S. Steel Corporation, the Responsible Operator, shall pay all benefits to which she is entitled under the Act, commencing as of October 1, 2002.

A

Stephen L. Purcell
Associate Chief Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your

appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).